		FOR OHF USE					

LL I

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041525

Facility Name: HERITAGE MANOR-LITCHFIELD

Address: 628 SOUTH ILLINOIS AVENUE (Number) LITCHFIELD (City) 61701 (Zip Code)

County: MONTGOMERY

Telephone Number: (217) 324-2153 **Fax #** ( )

IDPA ID Number: 370909086018

Date of Initial License for Current Owners: 03/01/96

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[xx]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[xx]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) CRAIG L. ATER

(Title) SENIOR V.P. FINANCE

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	102	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,728	10,924	1,738	31,390	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	18,728	10,924	1,738	31,390	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.88%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1996

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date 1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,738

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP CENSUS	DIFF
PP	11295	11295	0
IPA	18828	18828	0
medicare	1738	1738	0
	31861	31861	

IPA BEDHOLDS	100
PP BEDHOLDS	96
PP CONVERS	275

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	129,371	14,351	0	143,722		143,722	3,153	146,875			1
2	Food Purchase		157,888		157,888		157,888	(803)	157,085			2
3	Housekeeping	71,913	13,717		85,630		85,630	0	85,630			3
4	Laundry	38,996	19,608		58,604		58,604	0	58,604			4
5	Heat and Other Utilities			84,664	84,664		84,664	1,284	85,948			5
6	Maintenance	40,266	26,812	19,448	86,526		86,526	10,113	96,639			6
7	Other (specify):*							0				7
8	TOTAL General Services	280,546	232,376	104,112	617,034		617,034	13,747	630,781			8
	B. Health Care and Programs											
9	Medical Director			825	825		825	0	825			9
10	Nursing and Medical Records	1,003,392	36,691	3,777	1,043,860		1,043,860	0	1,043,860			10
10a	Therapy		85,424	80,968	166,392	(184,608)	(18,216)	92,109	73,893			10a
11	Activities	39,327	1,837	0	41,164		41,164	0	41,164			11
12	Social Services	64,808	0	2,271	67,079		67,079	0	67,079			12
13	Nurse Aide Training	3,502	2,393		5,895		5,895	1,885	7,780			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16		1,111,029	126,345	87,841	1,325,215	(184,608)	1,140,607	93,994	1,234,601			16
	C. General Administration											
17	Administrative	58,179			58,179		58,179	27,947	86,126			17
18	Directors Fees							4,376	4,376			18
19	Professional Services			204,826	204,826		204,826	(189,229)	15,597			19
20	Dues, Fees, Subscriptions & Promotions			74,727	74,727	(55,845)	18,882	(6,675)	12,207			20
21	Clerical & General Office Expenses	59,177	8,653	14,163	81,993		81,993	151,747	233,740			21
22	Employee Benefits & Payroll Taxes			254,801	254,801		254,801	21,540	276,341			22
23	Inservice Training & Education			358	358		358	827	1,185			23
24	Travel and Seminar			6,550	6,550		6,550	(4,551)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			23,719	23,719		23,719	1,550	25,269			26
27	Other (specify):*			21,829	21,829		21,829	(21,676)	153			27
28	TOTAL General Administration	117,356	8,653	600,973	726,982	(55,845)	671,137	(14,144)	656,993			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,508,931	367,374	792,926	2,669,231	(240,453)	2,428,778	93,597	2,522,375			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			128,174	128,174		128,174	6,798	134,972			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			268,144	268,144		268,144	(90)	268,054			32
33	Real Estate Taxes			60,299	60,299		60,299	0	60,299			33
34	Rent-Facility & Grounds			0				7,245	7,245			34
35	Rent-Equipment & Vehicles			8,398	8,398		8,398	11,707	20,105			35
36	Other (specify):*							0				36
37	TOTAL Ownership			465,015	465,015		465,015	25,660	490,675			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					184,608	184,608	0	184,608			39
40	Barber and Beauty Shops	10,602	347	1,254	12,203		12,203	0	12,203			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					55,845	55,845	0	55,845			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers	10,602	347	1,254	12,203	240,453	252,656		252,656			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,519,533	367,721	1,259,195	3,146,449	0	3,146,449	119,257	3,265,706			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,425)	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(803)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(492)	20		17
18	Fines and Penalties				18
19	Entertainment	(10,426)	24		19
20	Contributions	(180)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	0	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,496)	27		24
25	Fund Raising, Advertising and Promotional	(10,308)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	0	23		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (47,133)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	166,390		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 166,390		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 119,257		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Print Preview

Detail lines 29 and 25 of Page 5 starting in B44. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 6A**

Facility Name HERITAGE MANOR-LITCHFIELD

ID# 0041820

Report Period Beginning: 1/1/2021

Ending: 12/31/21

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G65 is from Page 5.				
1 **Day Care**	0	0	**Line 1**	0
2 **Other Care for Outpatients**	0	0	**Line 2**	(40)
3 **Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4 **Non-Patient Meals**	0	0	**Line 4**	0
5 **Telephone, TV & Radio in Resident Rooms**	(1,425)	35	**Line 5**	0
6 **Rented Facility Space**	0	34	**Line 6**	0
7 **Sale of Supplies to Non-Patients**	0		**Line 7**	0
8 **Laundry for Non-Patients**	0		**Line 8**	(66)
9 **Non-Nursing/Other Depreciation**	0	30	**Line 9**	0
10 **Interest and Other Investment Income**	(3)	32	**Line 10**	0
11 **Discounts, Allowances, Rebates & Refunds**	0		**Line 10a**	0
12 **Non-Working Officer's or Owner's Salary**	0		**Line 11**	0
13 **Sales Tax**	(603)	2	**Line 12**	0
14 **Non-Care Related Interest**	0	32	**Line 12**	0
15 **Non-Care Related Owner's Transactions**	0	33	**Line 14**	0
16 **Personal Expenses (Including Transportation)**	0	24	**Line 15**	0
17 **Non-Care Related Fees**	(692)	20	**Line 16**	0
18 **Fines and Penalties**	0		**Line 17**	0
19 **Entertainment**	(10,426)	24	**Line 18**	0
20 **Contributions**	(180)	27	**Line 19**	(66)
21 **Owner or Key Man Insurance**	0		**Line 20**	(10,000)
22 **Special Legal Fees & Legal Retainers**	0	19	**Line 21**	0
23 **Malpractice Insurance for Individuals**	0		**Line 22**	0
24 **Bad Debt**	(21,496)	27	**Line 23**	0
25 **Franchising, Advertising and Promotional**	(10,308)	20	**Line 24**	(10,000)
26 **Income & 1% Personal Property Replacement Taxes**	0	20	**Line 25**	(66)
27 **Nurse Aide Training for Non-Employees**	0	23	**Line 26**	0
28 **Yellow Page Advertising**	0	0	**Line 27**	(1,425)
29 **Non-Paid Workers**	0	0	**Line 28**	(10,426)
30 **Donated Goods**	0	0	**Line 29**	(43,703)
31 **Amortization Expense**	0	0	**Line 30**	0
32			**Line 31**	0
33			**Line 32**	(3)
34			**Line 33**	0
35			**Line 34**	0
36			**Line 35**	(1,425)
37			**Line 36**	0
38			**Line 37**	(1,425)
39			**Line 38**	0
40			**Line 39**	0
41			**Line 40**	0
42			**Line 41**	0
43			**Line 42**	0
44			**Line 43**	0
45			**Line 44**	0
46			**Line 45**	(43,703)
47				
48				
49				
50				
51				
52				
53				
54				
55				
56				
57				
58				
59				
60				
61				
62				
63				
64				
65				
66				
67				
68				
69				
70				
71				
72				
73				
74				
75				
76				
77				
78				
79				
80				
81				
82				
83				
84				
85				
86				
87				
88				
89				
90				
91				
92				
93				
94				
95				
96				
97				
98				
99				
100				
101				
102				
103				
104				
105				
106				
107				
108				
109				
110				
111				
112				
113				
114				
115				
116				
117				
118				
119				
120				
121				
122				
123				
124				
125				

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,153	0	0	0	0	0	0	0	0	3,153	1
2	Food Purchase	(803)	0	0	0	0	0	0	0	0	0	0	(803)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,284	0	0	0	0	0	0	0	0	1,284	5
6	Maintenance	0	0	10,113	0	0	0	0	0	0	0	0	10,113	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(803)	0	14,550	0	0	0	0	0	0	0	0	13,747	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(3,868)		0	95,977	0	0	0	0	0	0	92,109	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,885	0	0	0	0	0	0	0	0	1,885	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(3,868)	1,885	0	95,977	0	0	0	0	0	0	93,994	16
	C. General Administration													
17	Administrative	0	0	27,947	0	0	0	0	0	0	0	0	27,947	17
18	Directors Fees	0	0	4,376	0	0	0	0	0	0	0	0	4,376	18
19	Professional Services	0	0	10,731	0	(199,960)	0	0	0	0	0	0	(189,229)	19
20	Fees, Subscriptions & Promotions	(10,800)	0	4,125	0	0	0	0	0	0	0	0	(6,675)	20
21	Clerical & General Office Expenses	0	0	151,747	0	0	0	0	0	0	0	0	151,747	21
22	Employee Benefits & Payroll Taxes	0	0	21,540	0	0	0	0	0	0	0	0	21,540	22
23	Inservice Training & Education	0	0	827	0	0	0	0	0	0	0	0	827	23
24	Travel and Seminar	(10,426)	0	5,875	0	0	0	0	0	0	0	0	(4,551)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,550	0	0	0	0	0	0	0	0	1,550	26
27	Other (specify):*	(21,676)	0	0	0	0	0	0	0	0	0	0	(21,676)	27
28	**TOTAL General Administration**	(42,902)	0	228,718	0	(199,960)	0	0	0	0	0	0	(14,144)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(43,705)	(3,868)	245,153	0	(103,983)	0	0	0	0	0	0	93,597	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	6,798	0	0	0	0	0	0	0	6,798	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3)	0	0	(87)	0	0	0	0	0	0	0	(90)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	7,245	0	0	0	0	0	0	0	7,245	34
35	Rent-Equipment & Vehicles	(3,425)	0	0	15,132	0	0	0	0	0	0	0	11,707	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,428)	0	0	29,088	0	0	0	0	0	0	0	25,660	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(47,133)	(3,868)	245,153	29,088	(103,983)	0	0	0	0	0	0	119,257	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 4)	
1	V		$			$	$	1
2	V	10c Adjustment for Related Organization	77,420	Givenitive Therapy	100.00%	73,552	(3,868)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 77,420			$ 73,552	$ (3,868)	14

Sum_6 -3868

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 3,153	$ 3,153	15	3153
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				1,284	1,284	19	1284
20	V	6	Maintenance				10,113	10,113	20	10113
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				1,885	1,885	26	1885
27	V	14	Program Transportation				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				27,947	27,947	29	27947
30	V	18	Directors Fees				4,376	4,376	30	4376
31	V	19	Professional Services				10,731	10,731	31	10731
32	V	20	Fees, Subscription, Promotions				4,125	4,125	32	4125
33	V	21	Clerical & General Office Expenses				151,747	151,747	33	151747
34	V	22	Employee Benefits & Payroll Taxes				21,540	21,540	34	21540
35	V	23	Inservice Training & Education				827	827	35	827
36	V	24	Travel and Seminar				5,875	5,875	36	5875
37	V	25	Other Admin. Staff Transportation				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				1,550	1,550	38	1550
39	Total			$			$ 245,153	$ * 245,153	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V	30	Depreciation				6,798	6,798	16	6798
17	V	31	Amortization of Pre-Op & Org				0		17	
18	V	32	Interest				(87)	(87)	18	-87
19	V	33	Real Estate Taxes				0		19	
20	V	34	Rent-Facility & Grounds				7,245	7,245	20	7245
21	V	35	Rent-Equipment & Vehicles				15,132	15,132	21	15132
22	V	36	Other				0		22	
23	V	38	Medically Nec Transportation				0		23	
24	V	39	Ancillary Service Centers				0		24	
25	V	40	Barber and Beauty Shops				0		25	
26	V	41	Coffee and Gift Shops				0		26	
27	V	42	Other				0		27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 29,088	$ * 29,088	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	19	Adjustment for Related Organization	$ 199,960	Heritage Enterprises, Inc.		$	$ (199,960)	15	-199960
16	V								16	
17	V	10a	Adjustment for Related Organization	85,083	Green Tree Pharmacy	100.00%	181,060	95,977	17	95977
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 285,043			$ 181,060	$ * (103,983)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6E

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6E

Print Preview

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6F

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6F

Print Preview

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6G

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6G

Print Preview

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6H

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6H

Print Preview

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6I

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6I

Print Preview

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	25.98%	28,245	10	0.20	Directors Fee	$ 1,506	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Treas	Management	10.15%	28,245	10	0.20	Directors Fees	1,508	line 18, col 7	2
3	Craig Hart	Secretary/Treasurer	Management	20.00%	28,245	10	0.20	Directors Fees	1,508	line 18, col 7	3
	Joe Warner	President	Management	2.50%	10,087	48	0.95	Directors Fees	539	line 18, col 7	
4	Bill Froelich	Chairman of Board	Management	25.98%	97,437	10	0.20	Salary	5,201	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Treas	Management	10.15%	95,853	10	0.20	Salary	5,118	line 17, col 7	5
6	Craig Hart	Secretary/Treasurer	Management	20.00%	80,988	10	0.20	Salary	4,324	line 17, col 7	6
7	Joe Warner	President	Management	2.50%	109,049	48	0.95	Salary	5,822	line 17, col 7	7
8	Bob Dickson	Executive Vice Presid	Management	0.80%	59,351	50	1.00	Salary	3,169	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Presid	Management	0.31%	49,862	50	1.00	Salary	2,662	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Presid	Management	0.26%	48,262	50	1.00	Salary	2,577	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.17%	33,159	40	1.00	Salary	1,770	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.21%	31,564	50	1.00	Salary	1,685	line 17, col 7	12
13								TOTAL	$ 37,389		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,328	23	$ 71,961	$ 71,961	102	$ 3,153	1
2	2	Food Purchase	BEDS	2,328	23	0	0	102	0	2
3	3	Housekeeping	BEDS	2,328	23	0	0	102	0	3
4	4	Laundry	BEDS	2,328	23	0	0	102	0	4
5	5	Heat & Other Utilities	BEDS	2,328	23	29,301	0	102	1,284	5
6	6	Maintenance	BEDS	2,328	23	230,824	54,124	102	10,113	6
7	7	Other	BEDS	2,328	23	0	0	102	0	7
8	9	Medical Director	BEDS	2,328	23	0	0	102	0	8
9	10	Nursing & Medical Records	BEDS	2,328	23	0	0	102	0	9
10	11	Activities	BEDS	2,328	23	0	0	102	0	10
11	12	Social Service	BEDS	2,328	23	0	0	102	0	11
12	13	Nurse Aide Training	BEDS	2,328	23	43,025	0	102	1,885	12
13	14	Program Transportation	BEDS	2,328	23	0	0	102	0	13
14	15	Other	BEDS	2,328	23	0	0	102	0	14
15	17	Administrative	BEDS	2,328	23	637,854	637,854	102	27,947	15
16	18	Directors Fees	BEDS	2,328	23	99,885	0	102	4,376	16
17	19	Professional Services	BEDS	2,328	23	244,928	0	102	10,731	17
18	20	Fees, Subscription, Promotions	BEDS	2,328	23	94,145	0	102	4,125	18
19	21	Clerical & General Office Expense	BEDS	2,328	23	3,463,403	3,114,857	102	151,747	19
20	22	Employee Benefits & Payroll Taxe	BEDS	2,328	23	491,614	0	102	21,540	20
21	23	Inservice Training & Education	BEDS	2,328	23	18,866	0	102	827	21
22	24	Travel and Seminar	BEDS	2,328	23	134,093	0	102	5,875	22
23	25	Other Admin. Staff Transportatio	BEDS	2,328	23	0	0	102	0	23
24	26	Insurance-Prop.Liab.Malpract	BEDS	2,328	23	35,366	0	102	1,550	24
25	TOTALS					$ 5,595,265	$ 3,878,796		$ 245,153	25

Print Preview

Print Page 8A

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,328	23	$ 0	$ 0	102	$ 0	1
2	30	Depreciation	BEDS	2,328	23	155,150	0	102	6,798	2
3	31	Amortization of Pre-Op & Org	BEDS	2,328	23	0	0	102	0	3
4	32	Interest	BEDS	2,328	23	(1,990)	0	102	(87)	4
5	33	Real Estate Taxes	BEDS	2,328	23	0	0	102	0	5
6	34	Rent-Facility & Grounds	BEDS	2,328	23	165,362	0	102	7,245	6
7	35	Rent-Equipment & Vehicles	BEDS	2,328	23	345,363	0	102	15,132	7
8	36	Other	BEDS	2,328	23	0	0	102	0	8
9	38	Medically Nec Transportation	BEDS	2,328	23	0	0	102	0	9
10	39	Ancillary Service Centers	BEDS	2,328	23	0	0	102	0	10
11	40	Barber and Beauty Shops	BEDS	2,328	23	0	0	102	0	11
12	41	Coffee and Gift Shops	BEDS	2,328	23	0	0	102	0	12
13	42	Other	BEDS	2,328	23	0	0	102	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 663,885	$		$ 29,088	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8E

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	National City		XX	Mortage	$28,143.00	03/01/96	$ 3,409,430	$ 2,902,931	01/26/06	variable	$ 257,185	1
2	National City Loan Amortization		XX	Mortgage							5,766	2
3	Central Office Allocation		XX	Interest Income							(87)	3
4	Alpha Community Bank		xx			05/01/01	94,413	94,413	05/01/06	variable	5,193	4
5												5
	Working Capital											
6												6
7											0	7
8												8
9	TOTAL Facility Related				$28,143.00		$ 3,503,843	$ 2,997,344			$ 268,057	9
	B. Non-Facility Related*											
10	Interest Income										3	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3	14
15	TOTALS (line 9+line14)						$ 3,503,843	$ 2,997,344			$ 268,054	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$ 54,465	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 55,982	2
3. Under or (over) accrual (line 2 minus line 1).	$ 1,517	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 58,782	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 60,299	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill t the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered comple and timely filed until this statement and the corresponding real estate tax bills are filed. If you have an

To Print this page only

Hold down
Control Key and hit r

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HERITAGE MANOR-LITCHFIELD COUNTY MONTGOMERY

FACILITY IDPH LICENSE NUMBER 0041525

CONTACT PERSON REGARDING THIS REPORT CRAIG L. ATER

TELEPHONE (309)823-7135 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1600184800	HERITAGE MANOR-LITCHFIEL	$ 2,296	$ 2,296
2.	1600169801	HERITAGE MANOR-LITCHFIEL	$ 142	$ 142
3.	1600169100		$ 53,544	$ 53,544
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,982	$ 55,982

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1996	$ 19,316	1
2	Nursing Home				2
3	TOTALS			$ 19,316	3

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	102				$ 3,364,350	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Symmons Mixing Valve			1997	2,000						9
10	Boiler			1997	5,612						10
11	Dinning Room Roof Repair			1997	2,755						11
12	Roof Repair			1997	3,280						12
13											13
14	Laundry Room Central Air			1996	3,019						14
15	Heritage Manor Sign			1996	2,173						15
16											16
17	Roof			1998	60,674						17
18	Booster Heater			1998	1,717						18
19	Heat/Cool Units			1998	3,433						19
20	Garbage Disposal			1998	730						20
21											21
22											22
23				0							23
24											24
25											25
26				1999	920						26
27	Recirculating Pump			1999	2,046						27
28	Plumbing repairs/Replacement			1999	10,045						28
29	Carpet			1999	2,335						29
30	Interior Painting--Materials and Labor				0						30
31	Water Heater										31
32											32
33											33
34	C/O Allocation							6,798	6,798		34
35	Book Depreciation					90,400		90,400		510,964	35
36					3,465,089						36

* Total beds on this schedule must agree with page 2. See Page 12A, Line 70 for Total

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

0 Page 12B
0 Page 12C
0 Page 12D
0 Page 12E
0 Page 12F
0 Page 12G
0 Page 12H
0 Page 12I

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rooftop A/C Unit	2000	3,348						37
38	Blacktop Walkway	2000	2,250						38
39	Gazebo	2000	7,675						39
40									40
41	A/C Unit	2001	3,879						41
42	Gazebo	2001	981						42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 18,133	$ 90,400		$ 97,198	$ 6,798	$ 510,964	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 18,133	$ 0		$ 0	$	$ 510,964	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 18,133	$ 0		$ 0	$ 0	$ 510,964	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 18,133	$ 0		$ 0	$	$ 510,964	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 18,133	$ 0		$ 0	$ 0	$ 510,964	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 18,133	$ 0		$ 0	$	$ 510,964	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 18,133	$ 0		$ 0	$ 0	$ 510,964	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

To Print this page only

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

Hold down Control Key and hit t

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 18,133	$ 0		$ 0	$	$ 510,964	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 18,133	$ 0		$ 0	$ 0	$ 510,964	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 18,133	$ 0		$ 0	$	$ 510,964	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 18,133	$ 0		$ 0	$ 0	$ 510,964	34

**Improvement type must be detailed in order for the cost report to be considered complete.

To Print this page only

Hold down Control Key and hit w

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 270,621	$ 37,774	$ 37,774	$		$ 203,086	71
72	Current Year Purchases	16,831						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 287,452	$ 37,774	$ 37,774	$		$ 203,086	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,789,990	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 128,174	82
83	Straight Line Depreciation	(line 70, col.7 + line 75 ,col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,972	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,798	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 714,050	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 0			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ xx NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 20,105 Description: Copier, Cell Phone and Central Office Allocation
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		2,393		2,393
3	Classroom Wages (a)		3,502		3,502
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 5,895	$	$ 5,895
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,895			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 31,329	$		$ 31,329	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			11,562			11,562	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			30,661	341		31,002	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				181,060		181,060	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39/3				3,548			3,548	13
14	TOTAL			$		$ 77,100	$ 181,401		$ 258,501	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

pt adj -6551
st adj 6438
Ot adj -3755

drugs 95977

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 19,601	$	1
2	Cash-Patient Deposits	3,270		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	301,227		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,305		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	331,540		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 687,943	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	19,316		13
14	Buildings, at Historical Cost	3,483,222		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	287,452		16
17	Accumulated Depreciation (book methods)	(714,050)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	26,159		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,102,099	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,790,042	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 45,490	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,270		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,229		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,875		31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,782		32
33	Accrued Interest Payable	18,146		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 280,792	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,997,344		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,997,344	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,278,136	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 511,906	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,790,042	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 355,295	1
2	Restatements (describe):		2
3	audit Adjustment	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 355,293	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	156,613	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 156,613	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 511,906	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,305,775	1
2	Discounts and Allowances for all Levels	(304,384)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,001,391	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	128,691	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 128,691	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	3,724	11
12	Gift and Coffee Shop	3,322	12
13	Barber and Beauty Care	13,642	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	0	16
17	Sale of Drugs	152,283	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 172,977	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	3	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		0	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,303,062	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 617,034	31
32	Health Care	1,325,215	32
33	General Administration	726,982	33
	B. Capital Expense		
34	Ownership	465,015	34
	C. Ancillary Expense		
35	Special Cost Centers	12,203	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Non Nursing Home Revenue/Expense	0	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,146,449	40
41	**Income before Income Taxes (line 30 minus line 40)****	156,613	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 156,613	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,793	1,984	$ 37,771	$ 19.04	1
2	Assistant Director of Nursing	1,464	1,558	20,740	13.31	2
3	Registered Nurses	3,072	3,195	52,362	16.39	3
4	Licensed Practical Nurses	12,894	14,010	211,133	15.07	4
5	Nurse Aides & Orderlies	72,808	77,509	662,069	8.54	5
6	Nurse Aide Trainees	600	600	3,502	5.84	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,749	1,964	19,317	9.84	8
9	Activity Director					9
10	Activity Assistants	3,092	3,294	39,327	11.94	10
11	Social Service Workers	5,556	6,040	64,808	10.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,160	17,174	129,371	7.53	15
16	Dishwashers					16
17	Maintenance Workers	3,667	4,023	40,266	10.01	17
18	Housekeepers	9,342	10,522	71,913	6.83	18
19	Laundry	5,417	6,010	38,996	6.49	19
20	Administrator	2,080	2,080	58,179	27.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,264	5,814	59,177	10.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,958	155,777	$ 1,508,931 *	$ 9.69	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

Print Preview

0

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		825		36
37	Medical Records Consultant		712		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,586		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,271		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 6,394		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Wheeler	Administrator		$ 58,179
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,179

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 199,960
All Legal is adjusted to zero	Legal	0
SMS , Inc.	Reimbursement	4,866
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 204,826

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,690
Unemployment Compensation Insurance	14,498
FICA Taxes	115,433
Employee Health Insurance	69,384
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	14,796
Employee Benefits - central office	21,540
TOTAL (agree to Schedule V, line 22, col.8)	$ 276,341

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	953
Health Care Worker Background Check	
(Indicate # of checks performed)	700
Central Office Allocation	4,125
Promotional Advertising	4,217
Public Relations	6,091
Dues and Subscriptions	6,525
License and Fees	196
Less: Public Relations Expense	(6,091)
Non-allowable advertising	(492)
Yellow page advertising	(4,217)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,207

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,294
	186
Seminar Expense	4,070
Non Allowable	(10,426)
Central Office Allocation	5,875
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Print Preview

Facility Name & ID Number HERITAGE MANOR-LITCHFIELD # 0041525 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Print Preview

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **yes** If YES, have these costs
been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **5,000** Line _____

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? _____ YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO **xx** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **55,845**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **no** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **yes** Indicate the amount. $ **2,800**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? _____ If YES, please indicate the amount of income earned from such a
program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? _____
g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such
transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: **Sulaski & Webb** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **no** If no, please explain. **Not complete as of the filing date.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount					
1009			PETTY CASH	19601							1009	1009 PETTY CAS	19601	
1010			CASH IN BANK								1100	1100 ACCTS REC	301,227	
1040			CASH IN BANK-PAYROLL								1101	1101 ALLOW. FOR UNCOLLECTIBLES		
1100			ACCOUNTS RECEIVABLE	301227							1110	1110 ACCTS RECEIV-M/C		
1110			MEDICARE RECEIVABLES								1125	1125 ACCTS RECEIV-IPA		
1125			IPA INCOME RECEIVABLE								1135	1135 ACCTS RECEIV-IC		
1130			MEDICARE COST REPORT								1140	1140 UNAPPLIED CASH RECEIPTS		
1135			ACCOUNTS RECEIVABLE-IC								1145	1145 A/R SUSPENSE-REFUNDS		
1140			UNAPPLIED CASH RECEIPTS								1200	1200 PREPAID I	32305	
1145			A/R SUSPENSE-REFUNDS								1220	1220 OTHER PREPAID EXPENSES		
1190			ACCRUED INTEREST REC								1300	1300 DIETARY INVENTORY		
1200			PREPAID INSURANCE	32305							1310	1310 SUPPLIES INVENTORY		
1220			OTHER PREPAID EXPENSES								1320	1320 LINEN INVENTORY		
1300			FOOD INVENTORY								1409	1409 LAND	19,316	
1310			SUPPLIES INVENTORY								1450	1450 FURNITUR	287,452	
1409			LAND	19316							1460		-203086	
1450			FURNITURE & EQUIPMENT	287452							1475	1475 CODE ALE	3,483,222	
1460			ACCUM DEPR-FURN & EQUIP	-203086							1490	1490 ACCUM DE	(510,964)	
1475			BUILDING & IMPROVEMENTS	3483222							1530	1530 RESIDENT	3,270	
1490			ACCUM DEPR-BUILDING	-510964							1550	1550 LOAN FEES	26,160	
1530			RESIDENT FUNDS	3270							1551	1551 LOAN FEES ADDED		
1550			LOAN FEES	26160							1850	1850 INTERCOM	331,540	
1560			REAL ESTATE TAX ESCROW								2010	2010 ACCOUNTS	(45,490)	
1575			REIMBURSABLE PURCHASES								2100	2095 BONUSES PAYABLE		
1850			INTRACOMPANY	331540							2100	2100 ACCRUED	-75298	
2010			ACCOUNTS PAYABLE	-45490							2100	2100 PR CLEARING-BENEFITS		
2095			BONUSES PAYABLE								2100	2100 PR CLEARING-LABOR		
2100			ACCRUED PAYROLL	-75298							2110	2110 ACCRUED	-75931	
2110			ACCRUED VACATION PAY	-75931							2120	2120 U.C. TAXES PAYABLE		
2120			UC TAXES PAYABLE								2125	2125 FICA TAXES PAYABLE		
2125			FICA TAX PAYABLE	-3875	-3875						2130	2130 FEDERAL \	(3,875)	
2130			FIT PAYABLE								2140	2140 STATE W/H TAX PAYABLE		
2140			STATE W/H PAYABLE		0						2152	2152 WORKERS COMP ACCRUAL		
2145			EARNED INCOME CREDIT								2225	2225 EMPLOYEEE INSURANCE REFUND		
2150			UC FED CREDIT REDUCTION								2230	2230 PAYROLL SAVINGS		
2230			PAYROLL SAVINGS								2235	2240 UNITED FUND		
2235			IRA W/HOLDINGS								2240	2246 GROUP INSURANCE - CAFETERIA		
2240			UNITED WAY								2246	2250 401K W/H		
2245			GROUP INSURANCE PAYABLE								2250			
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2260	2260 WAGE GARNISHMENT		
2260			WAGE GARNISHMENTS								2300	2300 ACCRUED	(18,146)	
2280			MISC PAYROLL DEDUCTIONS								2320	2320 IPA PAYMENTS PAYABLE		
2300			ACCRUED INTEREST PAYABLE	-18146							2350	2350 REAL ESTA	-58782	
2310			SALES TAX PAYABLE								2385			
2320			IPA PAYMENTS PAYABLE	0							2400	2400 CURRENT PORTION OF LT DEBT		
2350			REAL ESTATE TAX PAYABLE	-58782							2512	2512 DUE TO RE	(3,270)	
2385			ACTIVITY FUND	0							2600	2600 LASALLE E	(2,902,931)	
2390			SECURITY DEPOSITS								2600			
2391			VOLUNTEER FUND								2625	2625 LASALLE C	(94,413)	
2393			HEART FUND/BAZAAR								2625			
2395			DEFERRED INC EMP & MEM								2695	2695 CURRENT PORTION OF LT DEBT		
2400			CURRENT PORTION LT DEBT								2720	2720 RETAINED	-355293	
2460			INCOME TAXES PAYABLE									net income	-156614	
2512			DUE TO RESIDENTS	-3270									0	
2600			MORTGAGE PAYABLE	-2997344										
2650			EQUIPMENT LOAN PAYABLE									balance	0	
2695			CURRENT PORTION LT DEBT											
2696			DEFERRED INCOME TAXES											
2710			COMMON STOCK											
2720			RETAINED EARNINGS	-355293										
2970			PROFIT/LOSS FOR PERIOD	-156614										
3007.1			PATIENT DAYS-PRIVATE	11295							3007	3007 PATIENT D	11,295	
3007.2			PATIENT DAYS-IPA	18828							3007	3007 PATIENT D	18,828	
3007.3			PATIENT DAYS-MEDICARE	1738							3007	3007 PATIENT D	1,738	
3007.4			PATIENT DAYS-CONVERSION								3007			
3007.5			PATIENT DAYS-LICENSED								3007			
3007.6			PATIENT DAYS-TOTAL								3007			
3010		1	BASIC CHARGE-PRIVATE & VA	-1228602		0	0	0	0		3007			
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		3010	3010 BASIC CHA	(1,228,602)	
3020		1	BASIC CHARGE-IPA	-1428426		0	0	0	0		3020	3020 BASIC CHA	(1,428,426)	
3030		1	BASIC CHARGE-MEDICARE	-447104		0	0	0	0		3030	3030 BASIC CHA	(447,104)	
3035		4	DAY CARE/HOME CARE			0	0	0	0		3040	3040 LIGHT NUI	(16,576)	
3040		1	LIGHT NURSING CARE	-84016		0	0	0	0		3050	3050 MEDIUM N	(38,430)	
3050		1	MEDIUM NURSING CARE			0	0	0	0		3060	3060 HEAVY NU	(24,254)	
3060		1	HEAVY NURSING CARE			0	0	0	0		3061	3061 SKILLED N	(4,756)	
3061		1	SKILLED NURSING CARE								3080	3080 NURSING S	(5,335)	
3080		1	NURSING SUPPLIES-PRIVATE	-93686		0	0	0	0		3081	3081 NURSING S	(45,981)	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		3082	3082 NURSING S	(9,160)	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		3083	3083 NURSING S	(33,210)	
3083		1	NURSING SUPPLIES MED PT B								3100	3100 DRUGS-ME	(63,005)	
3100		17	DRUGS	-152283		0	0	0	0		3101	3101 DRUGS-OT	(89,278)	
3101		17	DRUGS-OTHER								3110			
3110		6	PT-PRIVATE	(128,691)		0	0	0	0		3111			
3111		6	PT-IPA			0	0	0	0		3112	3112 PHYSICAL	(49,440)	
3112		6	PT-MEDICARE PART A			0	0	0	0		3113	3113 PHYSICAL	(7,521)	
3113		6	PT-MEDICARE PART B			0	0	0	0		3140	3140 LABORAT	(5,385)	
3130		1	PUBLIC AID ASSESSMENT INC								3150			
3140		19	LABORATORY INCOME			0	0	0	0		3151			
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		3152	3152 ST/OT THE	(52,560)	
3151		6	SPEECH/OT-IPA			0	0	0	0		3153	3153 ST/OT THE	(9,420)	
3152		6	SPEECH/OT-MED PART A			0	0	0	0		3160	3185 REHAB/ISC	(4,365)	
3153		6	SPEECH/OT MED PART B								3410	3410 IPA/OTHER	113,227	
3410		2	IPA DISCOUNTS	304384		0	0	0	0		3411	3411 MEDICARE	11,471	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		3420	3420 MEDICARE	179,686	
3420		2	MEDICARE DISCOUNTS			0	0	0	0		3500			
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		3520			
3520		16	RENT INCOME	0		6	0	6	0		3530	3530 BEAUTY SI	(13,642)	
3530		13	BEAUTY SHOP	-13642		0	0	0	0		3560			
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		3570	3570 VENDING I	(3,322)	
3570		12	VENDING INCOME/EXPENSE	-3322		0	0	0	0		3590	3590 EQUIPMEN	(23,941)	
3580		12	MANAGEMENT FEES			0	0	0	0		3595	3595 RESIDENT	(6)	
3590		1	EQUIPMENT RENTAL	-23941		0	0	0	0		3600			(3,299,335)
3595		21	RESIDENT TRANSPORTATION	-6		0	0	0	0		4110	4110 G&A WAGI	55,408	
3600		21	MISC INCOME	0		0	0	0	0		4111	4111 ADMINISTI	58,179	
4110			GENERAL & ADMINIST WAGES	55408	59,177	21	1	17	0		4115	4115 G&A PTO &	3,769	
4111			ADMINISTRATOR WAGES	58179	58179	17	1	0	0		4120	4120 EMPLOYEI	12,620	
4115			VACATION & SICK - G&A	3769		21	1	0	0		4125			
4120	4475		EMPLOYEE BENEFITS	12088	254801	22	3	0	0		4130	4130 EMPLOYEI	617	
4125			EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0		4135	4135 EMPLOYEI	2,091	
4130			EMPLOYEE SCHOLORSHIP WAGE	617		21	1	0	0		4250	4250 OFFICE SU	5,138	
4135			EMPLOYEE SCHOLORSHIP COST	2091		23	3	0	0		4255	4255 POSTAGE	2,981	
4220			DIRECTORS FEES			18	3	0	0		4260	4260 TELEPHON	14,163	
4250	4255		OFFICE SUPPLIES	8617	8653	21	2	0	0		4275	4275 TRAINING	358	
4260			TELEPHONE	14163	14163	21	3	0	0		4276	4276 INJURY PR	894	
4275			TRAINING & EMPLOYEE DEVL	358	358	23	3	16	0 ***		4280	4280 GENERAL	2,294	
4280			GENERAL TRAVEL	2294	6550	24	3	16	0		4281	4281 MEAL EXP	186	
4281			MEAL EXPENSE FOR TRAVEL	186		24	3	19	0		4285	4285 EDUCATIO	4,070	
4285			EDUCATION & SEMINAR	4070		24	3	19	-10426 ***		4289			
4290			HELP WANTED ADVERTISING	953	74727	20	3	0	0	-55845	4290	4290 HELP WAN	953	
4291			PROMOTIONAL ADVERTISING	4217		20	3	25	-4217		4291	4291 PROMOTIO	4,217	
4292			PUBLIC RELATIONS	6091		20	3	25	-6091		4292	4292 PUBLIC RE	6,091	
4300			LICENSES & FEES	56241		20	3	17	0		4300	4300 LICENSE &	56,241	
4310			DUES & SUBSCRIPTIONS	6525		20	3	17	-492		4310	4310 DUES & SU	6,525	
4320			CONTRIBUTIONS	180		27	3	20	-180		4320	4320 CONTRIBU	180	
4350			PROFESSIONAL FEES	4866	204826	19	3	22	0		4350	4350 PROFESSIC	4,866	
4355			MEDICAL DIRECTOR	825	825	9	3	0	0		4355	4360 UTILIZATI	825	
4360			UTILIZATION REVIEW	0		10	3	0	0		4362	4362 MEDICAL I	712	
4361			OTHER PHYSICIAN FEES	0		39	3	0	0		4363	4363 PHARMACI	2,586	
4362			MEDICAL RECORDS CONSULT	712		10	3	0	0		4364	4364 SOCIAL SE	2,271	
4363			PHARMACIST FEES	2586		10	3	0	0		4370	4370 TV RENTAI	3,425	
4364			SOC SERV/ACT CONSULT	2271	2271	12	3	0	0		4383	4383 BACKGROI	700	
4370			TV RENTAL	3425		35	3	5	-3425		4390			
4380			INCOME TAXES		21829	27	3	26	0		4400	4400 PAYROLL	125,235	
4383			BACKGROUND CHECKS	700		20	3	26	0		4401	4401 PAYROLL	4,696	
4400			PAYROLL TAXES	125,235		22	3	0	0		4410	4410 GROUP INS	69,384	
4401			PAYROLL TAXES ADMINIST	4696		22	3	0	0		4420	4420 LIABILITY	23,719	
4410			GROUP INSURANCE	69384		22	3	0	0		4430	4430 WORKMAN	37,362	
4420			LIABILITY INSURANCE	23719	23719	26	3	0	0		4435	4435 W/C-FIRST	1,551	
4425			INSURANCE-OWNERS			22	3	21	0		4436	4436 DRUG TEST	883	
4430			WORKMENS COMP INSURANCE	40690		22	3	0	0		4450	4450 CENTRAL (	199,960	
4450			CENTRAL OFFICE FEES	199960		19	3	34	-199960		4460	4460 BAD DEBT	19,899	
4460			BAD DEBTS	21496		27	3	24	-21496		4461	4461 BAD DEBT	1,597	
4470			LOST ITEMS-RESIDENTS	153		27	3	0			4470	4470 LOST ITEM	153	
4490			MISCELLANEOUS			27	3	0	0		4475	4475 UNIFORM I	(532)	
4510			REAL ESTATE TAXES	60299	60299	33	3	0	0		4486	4486 SERVICE C	3,432	
4600			LEASED EQUIPMENT	4973	8398	35	3	16	0		4490	4490 MISC EXPE	(1,354)	
5110			MAINTENANCE SALARIES	37732	40266	6	1	0	0		4496	4496 MISC. M.I.S	498	
5120			MAINTENANCE SICK & VAC	2534		6	1	0	0		4510	4510 REAL ESTA	60,299	
5130			ELECTRIC	30284	84664	5	3	0	0		4600	4600 LEASED EQ	4,973	
5131			NATURAL GAS	32625		5	3	0	0		5110	5110 MAINTENA	37,732	
5132			HEATING & DEISEL OIL			5	3	0	0		5120	5120 MAINTENA	2,534	
5133			WATER & SEWER	21755		5	3	0	0		5130	5130 ELECTRIC	30,284	
5134			TRASH COLLECTION	2541	19448	6	3	0	0		5131	5131 NATURAL	32,625	
5140			PROPERTY PLANT REPLACEMNT	3345	26812	6	2	0	0		5133	5133 WATER & S	21,755	
5160			GENERAL REPAIR & MAINT	23467		6	2	0	0		5134	5134 TRASH COI	2,541	
5165			MAINTENANCE CONTRACTS	16907		6	3	0	0		5140	5140 PROP/PLAN	3,345	
5210			DIETARY WAGES	122985	129371	1	1	0	0		5160	5160 GENERAL I	23,467	
5220			DIETARY SICK & VAC	6386		1	1	0	0		5165	5165 MAINTENA	13,475	
5240			SALES TAX			2	3	13	-803		5210	5210 DIETARY V	122,985	
5248			FOOD PURCHASES	160688	157888	2	2	0	0		5220	5220 DIETARY F	6,386	
5250			SUPPLIES-DISHWASHING	6643	14351	1	2	0	0		5248	5248 FOOD PUR	162,042	
5260			DIETARY REPLACEMENT	1255		1	2	0	0		5250	5250 SUPPLIES I	6,643	
5270			KITCHEN SUPPLIES-PAPER	6453		1	2	0	0		5260	5260 REPLACEM	1,255	
5295			MEAL CREDIT	-2800		2	2	0	0		5270	5270 KITCHEN S	6,453	
5310			LAUNDRY WAGES	37032	38996	4	1	0	0		5295	5295 MEAL INC	(2,800)	
5340			LAUNDRY SICK & VAC	1964		4	1	0	0		5310	5310 LAUNDRY	37,032	
5370			LAUNDRY REPLACEMENT	10903	19608	4	2	0	0		5340	5340 LAUNDRY	1,964	
5380			LAUNDRY REIMBURSEMENT	0		4	3	0	0		5370	5370 REPLACEM	10,903	
5390			LAUNDRY SUPPLIES	8,705		4	2	0	0		5380			
5410			HOUSEKEEPING WAGES	66981	71913	3	1	0	0		5390	5390 SUPPLIES	8,705	
5440			HOUSEKEEPING SICK & VAC	4932		3	1	0	0		5410	5410 HOUSEKEE	66,981	
5480			HOUSEKEEPING SUPPLIES	6393	13717	3	2	0	0		5440	5440 HOUSEKEE	4,932	
5490			HOUSEKEEPING SUPPLIES-PPR	7324		3	2	0	0		5480	5480 SUPPLIES-(	6,393	
6010			RN WAGES-MEDICARE		1003392	10	1	0	0		5490	5490 SUPPLIES-I	7,324	
6020			RN WAGES-NON MEDICARE	46598		10	1	0	0		6020	6020 RN WAGES	46,598	
6030			DON WAGES	37771		10	1	0	0		6030	6030 DON WAGI	37,771	
6035			ADON	20740		10	1	0	0		6035	6035 ADON WA(	20,740	
6040			RN SICK & VACATION	5764		10	1	0	0		6040	6040 RN PTO & I	5,764	
6110			LPN WAGES-MEDICARE			10	1	0	0		6120	6120 LPN WAGE	196,906	
6120			LPN WAGES-NON MEDICARE	196906		10	1	0	0		6140	6140 LPN PTO &	14,227	
6130			LPN WAGES OTHER			10	1	0	0		6220	6220 AIDES WA(	611,808	
6140			LPN SICK & VACATION	14227		10	1	0	0		6240	6240 AIDES PTO	50,261	
6210			AIDE WAGES-MEDICARE			10	1	0	0		6245			
6220			AIDE WAGES-NON MEDICARE	611808		10	1	0	0		6246			
6230			WARD CLERKS			10	1	0	0		6247			
6240			AIDE VACATION & SICK	50261		10	1	0	0		6250	6250 NURSE AID	3,502	
6245			CONTRACT NURSES-RN	0		10	3	0	0		6255	6255 NURSE AID	2,393	
6246			CONTRACT NURSES-LPN	0		10	3	0	0		6260	6260 NURSE AID	(3,724)	
6247			CONTRACT NURSES-AIDES	0		10	3	0	0		6270	6270 REHAB WA	17,898	
6250			NURSE AIDE TRAINING WAGES	3,502	3502	13	1	0	0		6275	6275 REHAB PT(	1,419	
6255			NURSE AID TRAINING EXP	2393	2393	13	2	0	0		6290	6290 NURSING S	29,816	
6260			NURSE AIDE TRAINING REIMB	(3,724)		0	0	0	0		6295	6295 NURSING S	5,370	
6270			REHAB WAGES	17898		10	1	0	0		6390	6390 REPLACEM	1,505	
6275			REHAB SICK & VAC	1419		10	1	0	0		6490	6490 OTHER	479	
6280			NURSING DEPT EDUCATION			23	3	0	0		7280	7280 DRUG PUR	33,124	
6290			NURSING SUPPLIES	29816	36691	10	2	0	0		7281	7281 DRUG PUR	51,959	
6295			NURSING SUPPLIES	5370		10	2	0	0		7380	7380 LABORATO	2,080	
6390			REPLACEMENT-NURSING	1505		10	2	0	0		7391	7390 X-RAY SER	937	
6490			NURSING OTHER	479	3777	10	3	0	0		7393	7393 OTHER A S	531	
7280			DRUG PURCHASES	33124	85424	39	2	0	95977 ***		7510	7510 ACTIVITIE	36,618	
7281			DRUG PURCHASES-OTHER	51959		39	2				7540	7540 ACTIVITIE	2,709	
7380			LABORATORY SERVICES	3,548	80,968	39	3	0	0		7590	7590 ACTIVITIE	1,837	
7410			HOME HEALTH SALARY			39	1	0	0		7620	7620 PHYSICAL	37,212	
7440			HOME HEALTH SICK & VAC			39	1	0	0		7660	7660 P.T. SUPPL	341	
7450			HOME HEALTH EXPENSES			39	3	0	0		7710	7710 SOCIAL SE	60,204	
7510			ACTIVITES WAGES	36618	39327	11	1	0	0		7720	7720 SOCIAL SE	4,604	
7540			ACTIVITIES SICK & VAC	2709		11	1	0	0		7730			
7590			ACTIVITIES SUPPLIES	1837	1837	11	2	0	0		7740	7740 OCCUPATI	35,084	
7595			ACTIVITIES FEES	0	0	11	3	0	0		7750			
7610			PT WAGES			39	1	0	0		7770	7770 SPEECH TH	5,124	
7611			PT SICK & VACATION			39	1	0	0		7820	7820 BEAUTICIA	1,254	
7620			PT FEES	37212		39	3	0	-6551 ***		7890	7890 BEAUTY SI	347	
7660			PT SUPPLIES	341		39	2	0	0		7960	7960 VOLUNTEI	36	
7710			SOCIAL SERVICE WAGES	60204	64808	12	1	0	0		8120	8120 INTEREST	235,365	
7720			SOCIAL SERVICE SICK & VAC	4604		12	1	0	0		8125	8125 ALLOCATE	27,013	
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		8130	8130 DEPRECIA	128,174	
7740			OT FEE	35084		39	3	0	-3755 ***		8150	8150 LOAN FEE	5,766	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		9510	9510 INTEREST	(3)	
7770			SPEECH THERAPY FEE	5124		39	3	0	6438 ***		9520			
7800			BEAUTICIAN WAGES	10,602	10602	40	1	0	0		9530			
7810			BEAUTICIAN SICK & VAC			40	1	0	0			4360 UTILIZATION REVIEW		
7820			BEAUTICIAN FEES	1254	1254	40	3	0	0			7800 BEAUTICIA	10,602	
7890			BEAUTY SHOP SUPPLIES	347	347	40	2	0	0			7595 ACTIVITIES FEES		
7910			VOLUNTEER COORDINATOR	0		21	1	0	0				(156,613)	
7940			VOL COORD SICK & VAC			21	1	0	0					
7960			VOL COORD SUPPLIES	36		21	2	0	0					
8100			RENT	0	0	34	3	0	0					
8120			INTEREST EXPENSE	262378	268144	32	3	14	-3					
8130			DEPRECIATION	128174	128174	30	3	9	0					
8150			LOAN FEE AMORTIZATION	5766		32	3	0	0	55845				
9510			INTEREST INCOME	-3		32	0	10	0					
9520			MISC NON-OPERATING INCOME	0		0	0	0	0					
9700			INCOME TAXES	0		0	0	0	0					
				3142722	3146449									
					3727									
GRAND TOTALS				-156613					-154984					
				(NET INCOME)										
				0										

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0
156613